

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09095

9097

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|---|----------------------------------|--|--|--|--|---|-------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Garrett | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 20 Months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | d. STREET ADDRESS LaFayette Ave. | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Cuppett Nursing Home | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First Ella | Middle Elizabeth | Last Anderson | 4. DATE OF DEATH August 23, 1958 | Month Month | Day Day | Year Year |
| S. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH Nov. 26, 1878 | | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Ellwood City, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Abram Thomas | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Doubt | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Cuppett Nursing Home | | Address Oakland, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Sclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO | | | | | | | | |
| (c) DUE TO | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. | | 20f. (City or town) 25 Cedar St | | (County) Oakland, Md. (State) MD |
| 21. I certify that I attended the deceased from Sept. 1957 to August 1958 , that I last saw the deceased alive on Aug. 1958 , and that death occurred at M. , from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) 812 3158 | | |
| ACTUAL SIGNATURE E. I. Baumgartner | | | | | | DATE SIGNED 25 Aug 1958 | | |
| PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 25, 1958 | | 22c. NAME OF CEMETERY OR CREMATORIUM Levels Cemetery | | 22d. LOCATION (City, town, or county) Levels, W. Va. (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 26 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |

STATE OF CALIFORNIA
DEPARTMENT OF REVENUE AND TAXES
DIVISION OF STATE TAXES

STATE TAXES
REFUND

BOOK 05
TAXES

REFUND BOOK

REFUND

REFUND BOOK

REFUND BOOK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09096

Reg. Dist. No.

| | | | | | | | | | |
|--|---|---|--|---|---|--|---------------------|-------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Garrett | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 1 Month | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE W. Va. | | b. COUNTY Grant | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayard | | d. STREET ADDRESS 85x-3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Anna | | First Amelia | Middle Arnold | Last | 4. DATE OF DEATH Aug. 18 1958 | Month Aug. | Day 18 | Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH Sept. 22 1867 | 9. AGE (In years lost birthday) 90 yrs. | IF UNDER 1 YEAR Months | Days | Hours | IF UNDER 24 HRS. Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Washington Arnold | | 14. MOTHER'S MAIDEN NAME Catherine Wolfe | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT A.H. Arnold | | Address Bayard, W.Va. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 | | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | Coronary Heart Failure Arterio sclerosis | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month 19 | Day | Year | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I attended the deceased from July , 19 58 , to Aug. 18 , 19 58 , that I last saw the deceased alive on Aug. 18 , 19 58 , and that death occurred at 759 Bayard , from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) M.D. 25ARDENST - OAKLAND MD. 8/18/58 | | | | | |
| ACTUAL SIGNATURE E. J. Baumgartner | | M.D. E. J. BAUMGARTNER MD. | | DATE SIGNED 8/18/58 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF Aug. 21, 1958 | 22c. NAME OF CEMETERY OR CREMATORIUM Maplespring | | 22d. LOCATION (City, town, or county) Eglon, W.Va. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle | | ADDRESS DAVIS, W.VA. | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | | |

BY DROWNING—HEAD TO TUMULTUOUS STATE QUAYAAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9099

CERTIFICATE OF DEATH

09097

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY GARRETT | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | c. LENGTH OF STAY IN 1b 27 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL — OAKLAND | |
| 3. NAME OF DECEASED (Type or print) LEWIS | | First M. | Middle BEACHY |
| 4. DATE OF DEATH AUGUST 20 1958 | Month Day Year | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH MAR. 25, 1871 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME MANASSAS BEACHY | |
| 14. MOTHER'S MAIDEN NAME ELIZABETH HEADING | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. ---- | | 17. INFORMANT ELI D. BEACHY | Address ROUTE # 2 — OAKLAND, MD. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Carcinoma of Rectum INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arterio sclerotic C.R.Disease 8 years DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1940 , to Aug 20 , 1958, that I last saw the deceased alive on 20 Aug , 1958, and that death occurred at 10:15P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Andrew E. Mance</i> | ADDRESS (Street, city or town, state) Oakland, Md. | | DATE SIGNED 21 Aug 58 |
| PHYSICIAN'S NAME (Type) ANDREW E. MANCE | OAKLAND, MARYLAND | | |
| 22a. BURIAL, CREMATION, Burial | 22b. DATE THEREOF 8/23/1958 | 22c. NAME OF CEMETERY OR CREMATORIUM Slabaugh Cemetery, near Gortner, Oakland, Md. | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leighton</i> | ADDRESS Oakland, Md. | 24a. REC'D BY REGISTRAR DATE AUG 25 '58 | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traas</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1626

BY BROWNE—HARVARD LIBRARY

BLAZER OF THE CROWN

1879

WILLIAM E. S. STOTES, Esq., Secretary, Commonwealth, Boston, Mass.

October 14, 1879

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09098

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Garrett | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL) Rural Oakland | | c. LENGTH OF STAY IN lb 8 Hrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Will O' The Wisp Motel | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle Phelps Last Carr | | d. STREET ADDRESS Brooklyn Bridge Road | |
| 4. DATE OF DEATH August 23, 1958 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 29, 1909 |
| 9. AGE (In years at birthday) 49 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 | |
| | | 11. IF UNDER 24 HRS. Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Engineer, Walter Reed Hospital | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland. | |
| 11. BIRTHPLACE (State or foreign country) Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Cuthbert Carr | | 14. MOTHER'S MAIDEN NAME Harriett Ann Bosley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-07-1423 | |
| 17. INFORMANT Martha Baldwin Carr | | Address Laurel, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute | | INTERVAL BETWEEN ONSET AND DEATH 5 minutes | |
| 420.1 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | DATE SIGNED 8-23-58 | |
| ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D (ACTING) | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 8/24/1958 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Oakland, Md. | | 22d. LOCATION (City, town, or county) Laurel, Maryland. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Keighlon</i> | | ADDRESS Oakland, Md. | |
| 24a. REC'D BY REGISTRAR AUG 25 '58 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | |

87-BROWNSVILLE, PENNSYLVANIA, ONE HUNDRED EIGHTY-THREE STATE HIGHWAYS
TOTAL LENGTH OF STATE HIGHWAYS - 9916

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09100

Reg. Dist. No.

9101

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH o. COUNTY Garrett MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 79 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Bertie C. Cleveland | | 4. DATE OF DEATH Last Month Day Year 8 8 1874 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH Jan. 16 1874 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 11. BIRTHPLACE (State or foreign country) Allegany |
| 13. FATHER'S NAME James O. Cleveland | | 14. MOTHER'S MAIDEN NAME Mary Catherine Parker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Mrs. Daisy Hinebaugh Address Terra Alta, W.Va |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urchinia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio. Renal disease DUE TO (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12-17, 1957, to 8-6, 1958, that I last saw the deceased alive on 18-6, 1958, and that death occurred at 2:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE James H. Feaster, Jr., M.D. ADDRESS 5821 St. Oakland and 8-8-58 PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/10/58 | 22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery |
| 22d. LOCATION (City, town, or county) Oakland (State) Maryland | | 24a. REC'D BY REGISTRAR DATE AUG 11 '58 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich | | ADDRESS Oakland, Maryland | |
| 24b. REGISTRAR'S SIGNATURE | | DeLoach | |

8 FEB 2001 11:58:14-1471A169378MA1403 STATE OWNERS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3102

CERTIFICATE OF DEATH

09101

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|--|----------------------------------|---|--|---|--|--|-------------------|-------------------------------|-----------------------|
| 1. PLACE OF DEATH o. COUNTY Garrett County | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Md. | | c. LENGTH OF STAY IN 1b RURAL and give nearest town) | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Baby Girl Edgar | | First Baby | Middle Girl | Last Edgar | 4. DATE OF DEATH August 30, 1958 | Month August | Day 30, | Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 30, 1958 | 9. AGE (In years lost birthday) yrs. 0 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 35 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? United States | | | |
| 13. FATHER'S NAME James William Edgar | | 14. MOTHER'S MAIDEN NAME Elliott, Mary Geneva | | Address McHenry, Maryland | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT James William Edgar | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO <i>Anoxia due to Cervical Dystocia - Breech Presentation</i> 1 hr 35 min INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c) | | DUE TO <i>Immaturity - 1 lb. 7 oz.</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) McHenry | | (County) Montgomery | (State) Md. |
| 21. I certify that I attended the deceased from Aug 30, 1958 , to Aug 30, 1958 , that I last saw the deceased alive on Aug 30, 1958 , and that death occurred at 12 P.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) 77 Oak St., Oakland, Md. | | DATE SIGNED 8/30/58 | | | |
| ACTUAL SIGNATURE <i>Herbert H. Leighton</i> | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D. | | 22c. NAME OF CEMETERY OR CREMATORIUM Edgar Family Cemetery | | 22d. LOCATION (City, town, or county) near McHenry, Md. | | (State) Md. | | | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22f. DATE THEREOF 8/31/1958 | | 24a. REC'D BY REGISTRAR DATE SEP 4 '58 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb Leighton</i> | | ADDRESS Oakland, Md. | | | | | | | |

CERTIFICATE OF DEATH

PAGE THREE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09102

| | | | | | |
|---|--|---|---|--|---|
| 9103 | | | | | |
| 1. PLACE OF DEATH a. COUNTY GARRETT | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | c. LENGTH OF STAY IN 1b 19 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) FRANCIS | | First | Middle | Last | 4. DATE OF DEATH Month AUGUST Day 20 Year 1958 |
| 5. SEX M | | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH MAR. 3, 1911 | 9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER | | 10b. KIND OF BUSINESS OR INDUSTRY General Store | | 11. BIRTHPLACE (State or foreign country) OHIO | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME JOSEPH GALLAGHER | | 14. MOTHER'S MAIDEN NAME ELIZABETH METZGER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 275-10-7531 | | 17. INFORMANT JUDY GALLAGHER | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150 X | | INTERVAL BETWEEN ONSET AND DEATH 6 months | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis | | DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 58 , to Aug 20 , 19 58 , that I last saw the deceased alive on Aug 20 , 19 58 , and that death occurred at 4:35 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 21 Aug 58 | | | |
| ACTUAL SIGNATURE Andrew E. Mance | | | | | |
| PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D. | | OAKLAND, MARYLAND | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) REMOVAL | | 22b. DATE THEREOF 8/21/1958 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. Martins Cemetery | |
| 22d. LOCATION (City, town, or county) St. Martins, Ohio. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton | | ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 25 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9104

CERTIFICATE OF DEATH

Reg. Dist. No.

09103

| | | | | | | | |
|--|--|---|---|---|---|---|--------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Garrett | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md | | b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Kitzmiller | | c. LENGTH OF STAY IN 1b 13 Yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural-Kitzmiller | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Star route #1 | | | | d. STREET ADDRESS / Star route 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ARTHUR JONATHAN HARVEY | | First ARTHUR | Middle JONATHAN | Last HARVEY | 4. DATE OF DEATH Month 8 | Day 27 | Year 58 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH Nov. 11, 1883 | 9. AGE (In years last birthday) 74 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 |
| 7. WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | | | | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station owner | | 10b. KIND OF BUSINESS OR INDUSTRY Gasoline station | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Sampson Harvey | | | | 14. MOTHER'S MAIDEN NAME Rachael Barnhouse | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Arthur J. Harvey-Kitzmiller, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X Uremia | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 weeks | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diverticulosis | | DUE TO 442 X | | Sclerotic cardio-renal disease with auricular fibrillation | | DUE TO 4 years. | |
| DUE TO 442 X | | (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverticulosis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 15, 1958 to June 15, 1958 , that I last saw the deceased alive on June 15th, 1958 , and that death occurred at 1 : 30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i> | | | | | | ADDRESS (Street, city or town, state) 58 2nd St., Oakland, Md. | |
| | | | | | | DATE SIGNED 8-27-58 | |
| PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/30/58 | | 22c. NAME OF CEMETERY OR CREMATORIUM Kalbaugh Cem | | 22d. LOCATION (City, town, or county) Elk garden, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Boal</i> | | ADDRESS Westernport, Md. | | 24a. REC'D BY REGISTRAR DATE SEP 2 1958 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Mann</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

卷1-210航行规则-子目A附录9 航行规则A部分37A和39A的修改

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10-W

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9105 CERTIFICATE OF DEATH

09104

Reg. Dist. No.

| | | | | | |
|---|------------------------------|--|---|---|---|
| 1. PLACE OF DEATH | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | GARRETT MARYLAND | | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | MARYLAND GARRETT | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS HOMESTEAD STREET | | | STREET ADDRESS (If rural give location) HOMESTEAD STREET | | |
| 3. NAME OF DECEASED (First) GEORGE (Middle) - (Last) KELIVITIS | | | 4. DATE (Month) OF DEATH AUG. 26, 1958 (Year) | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH APRIL 9, 1882 | 9. AGE last birthday 76 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-COAL MINER | | | 10b. KIND OF BUSINESS INDUSTRY COAL MINES | 11. BIRTHPLACE (State or foreign country) LITHUANIA | |
| 13. FATHER'S NAME GEORGE KELIVITIS | | | 14. MOTHER'S MAIDEN NAME MARY | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unk.) NO (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 216-01-0581 | | |
| 17. INFORMANT & ADDRESS Mrs. Phyllis Kevialitis-Kitzmiller | | | 18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Acute Convex Hemorrhage ANTECEDENT CAUSE(S) DUE TO Deleterious DISEASES OR CONDITIONS, IF ANY, (B) Convex Hemorrhage GIVING RISE TO THE ABOVE CAUSE DUE TO Deleterious STATING UNDERLYING CAUSE LAST. (C) 1/2 yr. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Silicosis 10 yrs. | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Feb. 1, 1958, to Aug. 26, 1958, that I last saw the deceased alive on Aug. 25, 1958, and that death occurred at 9:30 A.M. from the causes and on the date stated above. SIGNATURE Ralph Kalbaugh M.D. DATE SIGNED Aug 26 58 ADDRESS (Street, city, town, state) | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | DATE THEREOF 8/29/58 | NAME OF CEMETERY OR CREMATORIUM Kalbaugh Cemetery | LOCATION (City, town, or county) Elk Garden, Mineral Co., W. Va. (State) | |
| 24. REC'D BY REGISTRAR DATE SEP 2 '58 | | REGISTRAR'S SIGNATURE Arthur S. Knott | | 25. FUNERAL DIRECTOR'S SIGNATURE H. L. Leighton ADDRESS Oakland, Md. | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09105

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|---|------------------------------|--|---|--|---------------------------------------|---|-------------------|----------------------|
| 1. PLACE OF DEATH a. COUNTY GARRETT | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY GARRETT | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | c. LENGTH OF STAY IN 1b 1 mo.-14 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL — OAKLAND | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First JOSEPH | Middle ELSWORTH | Last KITZMILLER | 4. DATE OF DEATH | Month AUGUST | Day 10 | Year 19 58 |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 14, 1871 1877 | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME WILLIAM KITZMILLER | | | 14. MOTHER'S MAIDEN NAME ANNA BECHTEL | | | Address OAKLAND, MD. | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT CARL M. KITZMILLER | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO <i>Coronary occlusion</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH Indeterminate | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Uremia,</i> DUE TO (c) <i>Arteriosclerosis</i> | | | | | | 3 4 mos | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from 6-27 , 19 58 to 8-10 , 19 58 , that I last saw the deceased alive on 8-10 , 19 58 , and that death occurred at 8:20 P.M. from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) Oakland, Md. | | |
| ACTUAL SIGNATURE <i>Andrew E. Mance</i> | | | | | | DATE SIGNED 11 Aug 58 | | |
| PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D. | | | | | | OAKLAND, MARYLAND | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/13/58 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery | | 22d. LOCATION (City, town, or county) Oakland (State) Md | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Gerald J. Minich | | | ADDRESS Oakland Md. | | | 24a. REC'D BY REGISTRAR DATE AUG 18 '58 | | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9107

Item 1 Film G233 8-29-58 et

CERTIFICATE OF DEATH

09106

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY GARRETT | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ACCIDENT | | c. LENGTH OF STAY IN 1b 3 WKS. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Death occurred at home." | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Ada | | 4. DATE OF DEATH Aug 15 1958 | |
| First Ada | | Middle BROWN McConough | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH FEB 2, 1884 | |
| WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) Cove GARRETT Co. MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT HARRY W YEAGLEY, | | Address 6533 JACKSONS PITTSBURGH 6, PA | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Coronary Occlusion years. (c) DUE TO Coronary Arteriosclerosis years. (d) DUE TO Hypertension years. | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypostatic Pneumonia | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) No Injury. | |
| 20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m. — | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc. — | | 20f. (City or town) — | |
| (County) — | | (State) — | |
| 21. I certify that I attended the deceased from Aug 8, 1958 , to Aug 15, 1958 , that I last saw the deceased alive on Aug 8, 1958 , and that death occurred at 1145 N. W. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Edwin M. Price, M.D. 612 Logan Place, Confluence | |
| ACTUAL SIGNATURE Edwin M. Price, M.D. | | DATE SIGNED Aug 15 1958 | |
| PHYSICIAN'S NAME (Type) Edwin M. Price, M.D. | | | |
| 22o. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8/18/58 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL MONONGEHALA | | 22d. LOCATION (City, town, or county) NORTH BRADDOCK, PA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Don J Newman, Grantsville, Md | | ADDRESS — | |
| 24a. REC'D BY REGISTRAR AUG 18 1958 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

DEPARTMENT OF HEALTH - DIVISION OF
CERTIFICATE OF DEATH

Death Year: 1910

Death Month: July
Death Day: 20

Age at Death: 42

Sex: Male
Race: White

Marital Status: Single

Employment: Farmer
Occupation: Farmer

Residence: State

City: State
County: State

State: State

Country: United States

State: State

Country: United States

State: State

Country: United States

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9108

CERTIFICATE OF DEATH

09107

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|----------------------------------|--|---|--|---|---|---------------------------------------|--------------------------------------|-----------------------|
| 1. PLACE OF DEATH a. COUNTY Garrett | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Garrett | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN 1b 70 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oakland, | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home | | d. STREET ADDRESS Second St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Margaret | | First Lentz | Middle Lentz | Last Miller | 4. DATE OF DEATH August 1, 1958 | Month August | Day 1 | Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 16, 1876 | | 9. AGE (In years last birthday) 82 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Hours 0 | IF UNDER 24 HRS. Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME George J. Miller | | | | 14. MOTHER'S MAIDEN NAME Susan M. Offutt | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT T. O. Deffinbaugh | | Address Oakland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) Arteriosclerosis | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 yrs. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Oakland | | (County) Garrett | (State) Md. |
| 21. I certify that I attended the deceased from Sept 15, 1948 to Aug 1, 1958 , that I last saw the deceased alive on July 30, 1958 , and that death occurred at 3:30P M, from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) 2 Seeder St Oakland Md. | | | | | | | | | |
| ACTUAL SIGNATURE E. I. Baumgartner | | | | | | | | | |
| DATE SIGNED 8/2/58 | | | | | | | | | |
| PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. | | 22a. BURIAL, CREMATION, ETC. (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 8/3/1958 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton | | 22d. LOCATION (City, town, or county) Oakland, Md. | | | | | | | |
| ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 4 '58 | | | | | | | |
| | | 24b. REGISTRAR'S SIGNATURE W. L. Smith | | | | | | | |

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9109 CERTIFICATE OF DEATH**

09108

Reg. Dist. No.

| | | | | | | | | |
|---|-------------------------------|---|---------------------------------------|---|---|--|---------------|---|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY PRESTON | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORINTH, WEST VIRGINIA | | d. STREET ADDRESS 85 X-3 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) ROIE | | First FERN | Middle RINGER | Lost | 4. DATE OF DEATH | Month AUGUST | Doy 19 | Year 1958 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 2, 1888 | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR Months 4 Days 17 | IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) IOWA | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13. FATHER'S NAME SANDERS, DAVID N. | | | | 14. MOTHER'S MAIDEN NAME DUMIRE, ESTER GRACE | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | | | RINGER, SAMUEL W. | | CORINTH, WEST VIRGINIA | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 INTERVAL BETWEEN ONSET AND DEATH 1 hour Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive C.V.D. DUE TO 5 years } (c) Arteriosclerosis DUE TO 8 years | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Oakland (County) Md (State) 19 Aug 58 | | |
| 21. I certify that I attended the deceased from AUGUST 18 , 1958, to AUGUST 19 , 1958, that I last saw the deceased alive on AUGUST 19 , 1958, and that death occurred at 9:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE A. E. Mance M.D. ADDRESS Oakland, Md DATE SIGNED 19 Aug 58 PHYSICIAN'S NAME (Type) A. E. Mance | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 22, 1958 | | 22c. NAME OF CEMETERY OR CREMATORIUM Terra Alta Cemetery | | 22d. LOCATION (City, town, or county) Terra Alta, West Virginia (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Reedland FD No 46824 Terra Alta W. Va. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR AUG 22 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached, use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9110

CERTIFICATE OF DEATH

Reg. Dist. No.

09109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|--|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Garrett | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Crellin | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin | | d. STREET ADDRESS ----- | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Two M. S. Crellin | | | | d. STREET ADDRESS ----- | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First Albert | Middle Henry | Last Savage | 4. DATE OF DEATH Month August | Day 4, | Year 1958 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 21, 1921 | 9. AGE (In years (at birthday) yrs.) 37 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Hours 0 |
| 10a. DURABLE OCCUPATION (Give kind of work done during last of working life, even if retired) Coal Miner | | 10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mine | | 11. BIRTHPLACE (State or foreign country) Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Noah Savage | | 14. MOTHER'S MAIDEN NAME Sarah Sliger | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. W. W. #2 216-14-1391 | | 17. INFORMANT Mrs. Loretta Savage | | Address Crellin, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X | | Myocardial Infarction | | | | 15 minutes | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion, Acute | | | | | | 15 minutes | |
| (c) Rheumatic Heart Disease | | | | | | Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April , 19 58 to August , 19 58 , that I last saw the deceased alive on July 28 , 19 58 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Herbert H. Leighton</i> | | ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md. | | | | DATE SIGNED Aug 4, 1958 | |
| PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D. | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | |
| 22b. DATE THEREOF 8/7/1958 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery | | 22d. LOCATION (City, town, or county) (State) Oakland, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb Leighton</i> | | ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 6 '58 | | 24b. REGISTRAR'S SIGNATURE <i>Albert Leighton</i> | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9111

CERTIFICATE OF DEATH

Reg. Dist. No.

09110

| | | | | |
|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Garrett | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland | | c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aurora | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Rest Home | | d. STREET ADDRESS 85x-3 | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First Ida | Middle Jim | Last SCOTT | |
| 4. DATE OF DEATH | Month 8 | Day 9 | Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 14, 1876 | |
| 9. AGE (In years last birthday) yrs. 82 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | 11. BIRTHPLACE (State or foreign country) Barbersville, West Va. | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Sanford H. Scott | 14. MOTHER'S MAIDEN NAME Delia Creal | Address Aurora, W. Va. | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT Kathelyn Allen | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 442X DUE TO ARTERIOSCLEROTIC CARDIO-RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO CEREBRAL VASCULAR ACCIDENT, OLD (c) | INTERVAL BETWEEN ONSET AND DEATH 2 weeks. YEARS |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 5-82-1 st Oakland and | (County) (State) 8-8-58 |
| 21. I certify that I attended the deceased from Jan 1954 , to 8-8-58 , that I last saw the deceased alive on 8-8-58 , and that death occurred at 7 A. M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> ADDRESS (Street, city or town, state) 5-82-1 st Oakland and 8-9-58 | | | | |
| DATE SIGNED 8-9-58 | | | | |
| PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D. 58 2ND. ST., OAKLAND, MD. 8-9-58 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-11-58 | 22c. NAME OF CEMETERY OR CREMATORIUM Springhill Cemetery | 22d. LOCATION (City, town, or county) Charleston, West Va. | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Williams</i> | ADDRESS <i>Kingwood</i> | 24a. REC'D BY REGISTRAR DATE SEP 9 1958 | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09111

9112

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|--|---------------------------------------|--|---------------------|
| 1. PLACE OF DEATH o. COUNTY GARRETT | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND | | b. COUNTY GARRETT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X OAKLAND, MARYLAND | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | d. STREET ADDRESS STAR ROUTE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First ARTHUR | Middle GORMAN | Last THAYER | 4. DATE OF DEATH | Month AUGUST | Doy 15 | Year 1958 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH MARCH 26, 1891 | 9. AGE (In years lost birthday) yrs. 66 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR-THAYER'S BARN | | 10b. KIND OF BUSINESS OR INDUSTRY Motel | | 11. BIRTHPLACE (State or foreign country) OAKLAND, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THAYER, JOHN O. | | 14. MOTHER'S MAIDEN NAME Virginia Welch | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Phillips Thayer | | Address Oakland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| <i>Myocardial infarction</i> 3 days | | | | | | | |
| Coronary Occlusion 3 days | | | | | | | |
| Atherosclerosis Unknown | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 13 1958 to Aug 15 1958 , that I last saw the deceased alive on Aug 15 1958 , and that death occurred at 6:15 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Herbert H. Leighton, M.D.</i> ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md. DATE SIGNED 1958 | | | | | | | |
| PHYSICIAN'S NAME (Type) | | 77 OAK STREET, OAKLAND, MARYLAND AUG. 16, | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL SPECIES BURIAL | | 22b. DATE THEREOF 8/18/1958 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery | | 22d. LOCATION (City, town, or county) (State) Oakland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i> | | ADDRESS Oakland, Md. | | | | | |
| 24a. REC'D BY REGISTRAR DATE AUG 19 '58 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAMSON COUNTY TEXAS - SAMPLES FOR
TESTING

STATEMENT OF OWNERSHIP
OF PUBLICATION

44-1014

| NAME OF PUBLICATION | ADDRESS | TYPE OF PUBLICATION | ISSUE PRICE | CLASSIFICATION | OWNER | MANAGER | STREET ADDRESS | CITY AND STATE | ZIP CODE |
|--|----------------------------------|---------------------------|-------------|----------------|--|--|----------------------------------|----------------|----------|
| WILLIAMSON COUNTY CHAMBER OF COMMERCE | PO BOX 1000 BRENHAM, TX 77833 | NON-PARTISAN POLITICAL | 50¢ | NON-PROFIT | WILLIAMSON COUNTY CHAMBER OF COMMERCE | WILLIAMSON COUNTY CHAMBER OF COMMERCE | PO BOX 1000 BRENHAM, TX 77833 | BRENHAM, TX | 77833 |
| WILLIAMSON COUNTY CHAMBER OF COMMERCE | PO BOX 1000 BRENHAM, TX 77833 | NON-PARTISAN POLITICAL | 50¢ | NON-PROFIT | WILLIAMSON COUNTY CHAMBER OF COMMERCE | WILLIAMSON COUNTY CHAMBER OF COMMERCE | PO BOX 1000 BRENHAM, TX 77833 | BRENHAM, TX | 77833 |
| WILLIAMSON COUNTY CHAMBER OF COMMERCE | PO BOX 1000 BRENHAM, TX 77833 | NON-PARTISAN POLITICAL | 50¢ | NON-PROFIT | WILLIAMSON COUNTY CHAMBER OF COMMERCE | WILLIAMSON COUNTY CHAMBER OF COMMERCE | PO BOX 1000 BRENHAM, TX 77833 | BRENHAM, TX | 77833 |
| WILLIAMSON COUNTY CHAMBER OF COMMERCE | PO BOX 1000 BRENHAM, TX 77833 | NON-PARTISAN POLITICAL | 50¢ | NON-PROFIT | WILLIAMSON COUNTY CHAMBER OF COMMERCE | WILLIAMSON COUNTY CHAMBER OF COMMERCE | PO BOX 1000 BRENHAM, TX 77833 | BRENHAM, TX | 77833 |